House of Representatives

File No. 669

General Assembly

February Session, 2000

(Reprint of File No. 236)

Substitute House Bill No. 5287
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
April 27, 2000

An Act Concerning Emergency Medical Services Data Collection And Emergency Medical Dispatch.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-175 of the general statutes is repealed and the following is substituted in lieu thereof:

As used in this chapter and sections 9 to 12, inclusive, of this act, unless the context otherwise requires:

(1) "Emergency medical service system" means a system which provides for the arrangement of personnel, facilities and equipment for the efficient, effective and coordinated delivery of health care services under emergency conditions;

(2) "Patient" means an injured, ill, crippled or physically handicapped person requiring assistance and transportation;

(3) "Ambulance" means a motor vehicle specifically designed to carry patients;

(4) "Ambulance service" means an organization which transports patients;

(5) "Emergency medical technician" means an individual who has successfully completed the training requirements established by the **[**Commissioner of Public Health**]** commissioner and has been certified by the Department of Public Health;

(6) "Ambulance driver" means a person whose primary function is driving an ambulance;

(7) "Emergency medical technician instructor" means a person who is certified by the Department of Public Health to teach courses, the completion of which is required in order to become an emergency medical technician;

(8) "Communications facility" means any facility housing the personnel and equipment for handling the emergency communications needs of a particular geographic area;

(9) "Life saving equipment" means equipment used by emergency medical personnel for the stabilization and treatment of patients;

(10) "Emergency medical service organization" means any organization whether public, private or voluntary which offers transportation or treatment services to patients under emergency conditions;

(11) "Invalid coach" means a vehicle used exclusively for the transportation of nonambulatory patients, who are not confined to stretchers, to or from either a medical facility or the patient's home in nonemergency situations or utilized in emergency situations as a backup vehicle when insufficient emergency vehicles exist;

(12) "Rescue service" means any organization, whether profit or nonprofit, whose primary purpose is to search for persons who have become lost or to render emergency service to persons who are in dangerous or perilous circumstances;

(13) "Provider" means any person, corporation or organization, whether profit or nonprofit, whose primary purpose is to deliver medical care or services, including such related medical care services as ambulance transportation;

(14) "Commissioner" means the Commissioner of Public Health;

(15) "Paramedic" means a person licensed pursuant to section 20-206ll;

(16) "Commercial ambulance service" means an ambulance service which primarily operates for profit;

(17) "Licensed ambulance service" means a commercial ambulance service or a volunteer or municipal ambulance service issued a license by the commissioner;

(18) **[**"Certified ambulance services"**]** "Certified ambulance service" means a municipal or volunteer ambulance service issued a certificate by the commissioner;

(19) "Management service" means an organization which provides emergency medical technicians or paramedics to any entity including an ambulance service but does not include a commercial ambulance service or a volunteer or municipal ambulance service; **[**and**]**

(20) "Automatic external defibrillator" means a device that: (A) Is used to administer an electric shock through the chest wall to the heart; (B) contains internal decision-making electronics, microcomputers or special software that allows it to interpret physiologic signals, make medical diagnosis and, if necessary, apply therapy; (C) guides the user through the process of using the device by audible or visual prompts; and (D) does not require the user to employ any discretion or judgment in its use;

(21) "Mutual aid call" means a call for emergency medical services that, pursuant to the terms of a written agreement, is responded to by a secondary or alternate emergency medical services provider if the

primary or designated emergency medical services provider is unable to respond because such primary or designated provider is responding to another call for emergency medical services or the ambulance or nontransport emergency vehicle operated by such primary or designated provider is out of service. For purposes of this subdivision, "nontransport emergency vehicle" means a vehicle used by emergency medical technicians or paramedics in responding to emergency calls that is not used to carry patients;

(22) "Municipality" means the legislative body of a municipality or the board of selectmen in the case of a municipality in which the legislative body is a town meeting;

(23) "Primary service area" means a specific geographic area to which one designated emergency medical services provider is assigned for each category of emergency medical response services; and

(24) "Primary service area responder" means an emergency medical services provider who is designated to respond to a victim of sudden illness or injury in a primary service area.

Sec. 2. Section 19a-177 of the general statutes is repealed and the following is substituted in lieu thereof:

The commissioner shall:

(1) With the advice of the Office of Emergency Medical Services established pursuant to section 19a-178, as amended by this act, and of an advisory committee on emergency medical services and with the benefit of meetings held pursuant to subsection (b) of section 19a-184, adopt every five years a state-wide plan for the coordinated delivery of emergency medical services;

(2) License or certify the following: (A) Ambulance operations, ambulance drivers, emergency medical technicians and communications personnel; (B) emergency room facilities and

communications facilities; and (C) transportation equipment, including land, sea and air vehicles used for transportation of patients to emergency facilities and periodically inspect life saving equipment, emergency facilities and emergency transportation vehicles to insure that state standards are maintained;

(3) Annually inventory emergency medical services resources within the state, including facilities, equipment, and personnel, for the purposes of determining the need for additional services and the effectiveness of existing services;

(4) Review and evaluate all area-wide plans developed by the emergency medical services councils pursuant to section 19a-182 in order to insure conformity with standards issued by **[**said**]** the commissioner;

(5) Within thirty days of their receipt, review all grant and contract applications for federal or state funds concerning emergency medical services or related activities for conformity to policy guidelines and forward such application to the appropriate agency, when required;

(6) Establish such minimum standards and adopt such regulations in accordance with the provisions of chapter 54, as may be necessary to develop the following components of an emergency medical service system: (A) Communications, which shall include, but not be limited to, equipment, radio frequencies and operational procedures; (B) transportation services, which shall include, but not be limited to, vehicle type, design, condition and maintenance, life saving equipment and operational procedure; (C) training, which shall include, but not be limited to, emergency medical technicians, communications personnel, paraprofessionals associated with emergency medical services, firefighters and state and local police; and (D) emergency medical service facilities, which shall include, but not be limited to, categorization of emergency departments as to their treatment capabilities and ancillary services;

(7) Coordinate training of all personnel related to emergency

medical services;

(8) **[**Develop**]** (A) Not later than October 1, 2001, develop or cause to be developed a data collection system **[**which shall include a method of uniform patient record keeping which**]** that will follow a patient from initial entry into the emergency medical service system through **[**discharge from**]** arrival at the emergency room. The commissioner shall, on a quarterly basis, collect the following information from each licensed ambulance service or certified ambulance service that provides emergency medical services: (i) The total number of calls for emergency medical services received by such licensed ambulance service or certified ambulance service through the 9-1-1 system during the reporting period; (ii) each level of emergency medical services, as defined in regulations adopted pursuant to section 19a-179, as amended by this act, required for each such call; (iii) the response time for each licensed ambulance service or certified ambulance service during the reporting period; (iv) the number of passed calls, cancelled calls and mutual aid calls during the reporting period; and (v) for the reporting period, the prehospital data for the nonscheduled transport of patients required by regulations adopted pursuant to subdivision (6) of this section. The information required under this subdivision may be submitted in any written or electronic form selected by such licensed ambulance service or certified ambulance service and approved by the commissioner, provided the commissioner shall take into consideration the needs of such licensed ambulance service or certified ambulance service in approving such written or electronic form. The commissioner may conduct an audit of any such licensed ambulance service or certified ambulance service as the commissioner deems necessary in order to verify the accuracy of such reported information.

(B) The commissioner shall prepare a report that shall include, but not be limited to, the following information: (i) The total number of calls for emergency medical services received during the reporting year by each licensed ambulance service or certified ambulance service; (ii) the level of emergency medical services required for each

such call; (iii) the name of the provider of each such level of emergency medical services furnished during the reporting year; (iv) the response time, by time ranges or fractile response times, for each licensed ambulance service or certified ambulance service, using a common definition of response time, as provided in regulations adopted pursuant to section 19a-179, as amended by this act; and (v) the number of passed calls, cancelled calls and mutual aid calls during the reporting year. The commissioner shall prepare such report in a format that categorizes such information for each municipality in which the emergency medical services were provided, with each such municipality grouped according to urban, suburban and rural classifications. Not later than March 31, 2002, and annually thereafter, the commissioner shall submit such report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, shall make such report available to the public and shall post such report on the Department of Public Health web site on the Internet.

(C) If any licensed ambulance service or certified ambulance service does not submit the information required under subparagraph (A) of this subdivision for a period of six consecutive months, or if the commissioner believes that such licensed ambulance service or certified ambulance service knowingly or intentionally submitted incomplete or false information, the commissioner shall issue a written order directing such licensed ambulance service or certified ambulance service to comply with the provisions of subparagraph (A) of this subdivision and submit all missing information or such corrected information as the commissioner may require. If such licensed ambulance service or certified ambulance service fails to fully comply with such order not later than three months from the date such order is issued, the commissioner (i) shall conduct a hearing, in accordance with chapter 54, at which such licensed ambulance service or certified ambulance service shall be required to show cause why the primary service area assignment of such licensed ambulance service or certified ambulance service should not be revoked, and (ii) may take such

disciplinary action under section 19a-17 as the commissioner deems appropriate.

(D) On and after October 1, 2006, the commissioner shall collect the information required by subparagraph (A) of this subdivision, in the manner provided in said subparagraph, from each person or emergency medical service organization licensed or certified under section 19a-180, as amended by this act, that provides emergency medical services. On and after October 1, 2006, such information shall be included in the annual report prepared by the commissioner in accordance with subparagraph (B) of this subdivision and such person or emergency medical service organization shall be subject to the provisions of subparagraph (C) of this subdivision; **[**and**]**

(9) (A) Establish rates for the conveyance of patients by licensed ambulance services and invalid coaches and establish **[**an**]** emergency service **[**rate**]** rates for certified ambulance services, provided the present rates established **[**by the Public Utilities Commission**]** for such services and vehicles shall remain in effect until such time as the commissioner establishes a new rate schedule as provided **[**herein,**]** in this subdivision; and (B) adopt regulations, in accordance with the provisions of chapter 54, establishing methods for setting rates and conditions for charging such rates. Such regulations shall include, but not be limited to, provisions requiring that on and after July 1, 2000: (i) Requests for rate increases may be filed no more frequently than once a year; (ii) only licensed ambulance services and certified ambulance services that apply for a rate increase and do not accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall be required to file detailed financial information with the commissioner; (iii) licensed ambulance services and certified ambulance services that do not apply for a rate increase in any year or that accept the maximum allowable rates contained in any voluntary state-wide rate schedule established by the commissioner for the rate application year shall, not later than July fifteenth of such year, file with the commissioner either an audited financial statement or an accountant's

review report pertaining to the most recently completed fiscal year of the licensed ambulance service or certified ambulance service, including total revenue and total expenses, a statement of emergency and nonemergency call volume, and, in the case of a licensed ambulance service or certified ambulance service that is not applying for a rate increase, a written declaration by such licensed ambulance service or certified ambulance service that no change in its currently approved maximum allowable rates will occur for the rate application year; and (iv) detailed financial and operational information filed by licensed ambulance services and certified ambulance services to support a request for a rate increase shall cover the time period pertaining to the most recently completed fiscal year and the rate application year of the licensed ambulance service or certified ambulance service;

(10) Research, develop, track and report on appropriate quantifiable outcome measures for the state's emergency medical services system and submit to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on or before July 1, 2002, and annually thereafter, a report on the progress toward the development of such outcome measures and, after such outcome measures are developed, an analysis of emergency medical services system outcomes;

(11) Establish primary service areas and assign in writing a primary service area responder for each primary service area; and

(12) Revoke primary services area assignments upon determination by the commissioner that it is in the best interests of patient care to do so.

Sec. 3. Section 19a-178 of the general statutes is amended by adding subsection (c) as follows:

(NEW) (c) Not later than July 1, 2001, the Office of Emergency Medical Services shall, with the advice of the Emergency Medical

Services Advisory Board established pursuant to section 19a-178a and the regional emergency medical services councils established pursuant to section 19a-183, develop model local emergency medical services plans and performance agreements to guide municipalities in the development of such plans and agreements. In developing the model plans and agreements, the office shall take into account (1) the differences in the delivery of emergency medical services in urban, suburban and rural settings, (2) the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177, as amended by this act, and (3) guidelines or standards and contracts or written agreements in use by municipalities of similar population and characteristics.

Sec. 4. Section 19a-179 of the general statutes is repealed and the following is substituted in lieu thereof:

The **[**Commissioner of Public Health**]** commissioner shall adopt regulations, in accordance with chapter 54, concerning the methods and conditions for licensure and certification of the operations, facilities and equipment enumerated in section 19a-177, as amended by this act, and regulations regarding complaint procedures for the public and any emergency medical service organization. Such regulations shall be **[**adopted in accordance with the provisions of chapter 54 and shall be**]** in conformity with the policies and standards established by the commissioner. Such regulations shall require that, as an express condition of the purchase of any business holding a primary service area, the purchaser shall agree to abide by any performance standards to which the purchased business was obligated pursuant to its agreement with the municipality.

Sec. 5. Section 19a-180 of the general statutes is repealed and the following is substituted in lieu thereof:

(a) No person shall operate any ambulance service, rescue service or management service without either a license or a certificate issued by the **[**Commissioner of Public Health**]** commissioner. No person shall

operate a commercial ambulance service or commercial rescue service or a management service without a license issued by the commissioner. A certificate shall be issued to any volunteer or municipal ambulance service which shows proof satisfactory to the commissioner that it meets the minimum standards of the commissioner in the areas of training, equipment and personnel. Applicants for a license shall use the forms prescribed by the commissioner and shall submit such application to the commissioner accompanied by an annual fee of one hundred dollars. In considering requests for approval of permits for new or expanded emergency medical services in any region, the commissioner shall consult with the Office of Emergency Medical Services and the emergency medical services council of such region and shall hold a public hearing to determine the necessity for such services. Written notice of such hearing shall be given to current providers in the geographic region where such new or expanded services would be implemented, provided, [that] any volunteer ambulance service which elects not to levy charges for services rendered under this chapter shall be exempt from the provisions concerning requests for approval of permits for new or expanded emergency medical services [,] set forth [above] in this subsection. Each applicant for licensure shall furnish proof of financial responsibility which the commissioner deems sufficient to satisfy any claim. The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to establish satisfactory kinds of coverage and limits of insurance for each applicant for either licensure or certification. Until such regulations are adopted, the following shall be the required limits for licensure: (1) For damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident, at least one million dollars, (2) for damage to property at least fifty thousand dollars, and (3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars. In lieu of the [foregoing] limits set forth in subdivisions (1) to (3), inclusive, of this subsection, a single limit of

liability shall be allowed as follows: (A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and (B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars. A certificate of such proof shall be filed with the commissioner. Upon determination by the commissioner that an applicant is financially responsible, properly certified and otherwise qualified to operate a commercial ambulance service, the commissioner shall issue a license effective for one year to such applicant. If the commissioner determines that an applicant for either a certificate or license is not so qualified, the commissioner shall notify such applicant of the denial of **[**his**]** the application with a statement of the reasons for such denial. Such applicant shall have thirty days to request a hearing on the denial of **[**said**]** the application.

(b) Any person or emergency medical **[**services**]** service organization which does not maintain standards or violates regulations adopted under any section of this chapter applicable to such person or organization may have **[**his or its**]** such person's or organization's license or certification suspended or revoked or may be subject to any other disciplinary action specified in section 19a-17 after notice by certified mail to such person or organization of the facts or conduct which warrant the intended action. Such person or emergency medical **[**services**]** service organization shall have an opportunity to show compliance with all requirements for the retention of such certificate or license. In the conduct of any investigation by the commissioner of alleged violations of the standards or regulations adopted under the provisions of this chapter, the commissioner may issue subpoenas requiring the attendance of witnesses and the production by any medical **[**services**]** service organization or person of reports, records, tapes or other documents which concern the allegations under investigation. All records obtained by the commissioner in connection with any such investigation shall not be subject to the provisions of section 1-210, as amended, for a period of six months from the date of the petition or other event initiating such

investigation, or until such time as the investigation is terminated pursuant to a withdrawal or other informal disposition or until a hearing is convened pursuant to chapter 54, whichever is earlier. A complaint, as defined in subdivision (6) of section 19a-13, shall be subject to the provisions of section 1-210, as amended, from the time that it is served or mailed to the respondent. Records which are otherwise public records shall not be deemed confidential merely because they have been obtained in connection with an investigation under this chapter.

(c) Any person or emergency medical service organization aggrieved by an act or decision of the commissioner regarding certification or licensure may appeal in the manner provided by chapter 54.

(d) Any person guilty of any of the following acts shall be fined not more than two hundred fifty dollars, or imprisoned not more than three months, or be both fined and imprisoned: (1) In any application to the commissioner or in any proceeding before or investigation made by the commissioner, knowingly making any false statement or representation, or, with knowledge of its falsity, filing or causing to be filed any false statement or representation in a required application or statement; (2) issuing, circulating or publishing or causing to be issued, circulated or published any form of advertisement or circular for the purpose of soliciting business which contains any statement that is false or misleading, or otherwise likely to deceive a reader thereof, with knowledge that it contains such false, misleading or deceptive statement; (3) giving or offering to give anything of value to any person for the purpose of promoting or securing ambulance or rescue service business or obtaining favors relating thereto; (4) administering or causing to be administered, while serving in the capacity of an employee of any licensed ambulance or rescue service, any alcoholic liquor to any patient in **[**his**]** such employee's care, except under the supervision and direction of a licensed physician; (5) in any respect wilfully violating or failing to comply with any provision of this chapter or wilfully violating, failing, omitting or neglecting to obey or

comply with any regulation, order, decision or license, or any part or provisions thereof; (6) with one or more other persons, conspiring to violate any license or order issued by the commissioner or any provision of this chapter.

(e) No person shall place any advertisement or produce any printed matter that holds that person out to be an ambulance service unless **[**he**]** such person is licensed or certified pursuant to this section. Any such advertisement or printed matter shall include the license or certificate number issued by the commissioner.

Sec. 6. Subsection (c) of section 28-24 of the general statutes is repealed and the following is substituted in lieu thereof:

(c) Within a time period determined by the commissioner to ensure the availability of funds for the fiscal year beginning July 1, 1997, to the regional public safety emergency telecommunications centers within the state, and not later than April first of each year thereafter, the commissioner shall determine the amount of funding needed for the development and administration of the enhanced emergency 9-1-1 program. The commissioner shall specify the expenses associated with (1) the purchase, installation and maintenance of new public safety answering point terminal equipment, (2) the implementation of the subsidy program, as described in subdivision (2) of subsection (a) of this section, (3) the implementation of the transition grant program, described in subdivision (2) of subsection (a) of this section, (4) the implementation of the regional emergency telecommunications service credit, as described in subdivision (2) of subsection (a) of this section, provided, for the fiscal year ending June 30, 2001, and each fiscal year thereafter, such credit for coordinated medical emergency direction services as provided in regulations adopted under this section shall be based upon the factor of fifteen cents per capita and shall not be reduced each year, (5) the training of personnel, as necessary, (6) recurring expenses and future capital costs associated with the telecommunications network used to provide emergency 9-1-1 service, **[**and**]** (7) for the fiscal year ending June 30, 2001, and each fiscal year

thereafter, the collection, maintenance and reporting of emergency medical services data, as required under subparagraphs (A) and (B) of subdivision (8) of section 19a-177, as amended by this act, provided the amount of expenses specified under this subdivision shall not exceed two hundred fifty thousand dollars in any fiscal year, (8) for the fiscal year ending June 30, 2001, and each fiscal year thereafter, the initial training of emergency medical dispatch personnel, the provision of an emergency medical dispatch priority reference card set and emergency medical dispatch training and continuing education pursuant to subdivisions (3) and (4) of subsection (g) of section 28-25b, as amended by this act, and (9) the administration of the enhanced emergency 9-1-1 program by the Office of State-Wide Emergency Telecommunications, as the commissioner determines to be reasonably necessary. The commissioner shall communicate **[**his**]** the commissioner's findings to the **[**chairman**]** chairperson of the Public Utilities Control Authority not later than April first of each year.

Sec. 7. Section 28-25 of the general statutes is amended by adding subdivision (15) as follows:

(NEW) (15) "Emergency medical dispatch" means the management of requests for emergency medical assistance by utilizing a system of (A) tiered response or priority dispatching of emergency medical resources based on the level of medical assistance needed by the victim, and (B) prearrival first aid or other medical instructions given by trained personnel who are responsible for receiving 9-1-1 calls and directly dispatching emergency response services.

Sec. 8. Section 28-25b of the general statutes is repealed and the following is substituted in lieu thereof:

(a) Each public safety answering point shall be capable of transmitting requests for law enforcement, fire fighting, medical, ambulance or other emergency services to a public or private safety agency that provides the requested services.

(b) Each public safety answering point shall be equipped with a

system approved by the office for the processing of requests for emergency services from the physically disabled.

(c) No person shall connect to a telephone company's network any automatic alarm or other automatic alerting device which causes the number "9-1-1" to be automatically dialed and provides a prerecorded message in order to directly access emergency services, except for a device approved by the office and required by a physically disabled person to access a public safety answering point.

(d) Except as provided in subsection (e) of this section, no person, firm or corporation shall program any telephone or associated equipment with outgoing access to the public switched network of a telephone company so as to prevent a 9-1-1 call from being transmitted from such telephone to a public safety answering point.

(e) A private company, corporation or institution which has full-time law enforcement, fire fighting and emergency medical service personnel, with the approval of the office and the municipality in which it is located, may establish 9-1-1 service to enable users of telephones within their private branch exchange to reach a private safety answering point by dialing the digits "9-1-1". Such 9-1-1 service shall provide the capability to deliver and display automatic number identification and automatic location identification by electronic or manual methods approved by the office to the private safety answering point. Prior to the installation and utilization of such 9-1-1 service, each municipality in which it will function, shall submit a private branch exchange 9-1-1 utilization plan to the office in a format approved by the office. Such plan shall be approved by the chief executive officer of such municipality who shall attest that the dispatch of emergency response services from a private safety answering point is equal to, or better than, the emergency response services dispatched from a public safety answering point.

(f) On and after January 1, 2001, each public safety answering point shall submit to the office, on a quarterly basis, a report of the calls for

emergency medical services received by the public safety answering point. Such report shall include, but not be limited to, the following information: (1) The number of 9-1-1 calls during the reporting quarter that involved a medical emergency; and (2) for each such call, the elapsed time period from the time the call was received to the time the call was answered, and the elapsed time period from the time the call was answered to the time emergency response services were dispatched or the call was transferred or relayed to another public safety agency or private safety agency, expressed in time ranges or fractile response times. The information required under this subsection may be submitted in any written or electronic form selected by such public safety answering point and approved by the Commissioner of Public Safety, provided the commissioner shall take into consideration the needs of such public safety answering point in approving such written or electronic form. On a quarterly basis, the office shall furnish such information to the Commissioner of Public Health, shall make such information available to the public and shall post such information on its web site on the Internet.

(g) (1) Not later than July 1, 2004, each public safety answering point shall provide emergency medical dispatch, or shall arrange for emergency medical dispatch to be provided by a public safety agency, private safety agency or regional emergency telecommunications center, in connection with all 9-1-1 calls received by such public safety answering point for which emergency medical services are required. Any public safety answering point that arranges for emergency medical dispatch to be provided by a public safety agency, private safety agency or regional emergency telecommunications center shall file with the office such documentation as the office may require to demonstrate that such public safety agency, private safety agency or regional emergency telecommunications center satisfies the requirements of subdivisions (2) and (3) of this subsection.

(2) Each public safety answering point, public safety agency, private safety agency or regional emergency telecommunications center performing emergency medical dispatch in accordance with

subdivision (1) of this subsection shall establish and maintain an emergency medical dispatch program. Such program shall include, but not be limited to, the following elements: (A) Medical interrogation, dispatch prioritization and prearrival instructions in connection with 9-1-1 calls requiring emergency medical services shall be provided only by personnel who have been trained in emergency medical dispatch through satisfactory completion of a training course provided or approved by the office under subdivision (3) of this subsection; (B) a medically approved emergency medical dispatch priority reference system shall be utilized by such personnel; (C) emergency medical dispatch continuing education shall be provided for such personnel; (D) a mechanism shall be employed to detect and correct discrepancies between established emergency medical dispatch protocols and actual emergency medical dispatch practice; and (E) a quality assurance component shall be implemented to monitor, at a minimum, (i) emergency medical dispatch time intervals, (ii) the utilization of emergency medical dispatch program components, and (iii) the appropriateness of emergency medical dispatch instructions and dispatch protocols. The quality assurance component shall be prepared with the assistance of a physician licensed in this state who is trained in emergency medicine and shall provide for an ongoing review of the effectiveness of the emergency medical dispatch program.

(3) Not later than July 1, 2001, the office shall provide an emergency medical dispatch training course and an emergency medical dispatch continuing education course, or approve any emergency medical dispatch training course and emergency medical dispatch continuing education course offered by other providers, that meets the requirements of the U.S. Department of Transportation, National Highway Traffic Safety Administration, Emergency Medical Dispatch (EMD): National Standard Curriculum, as from time to time amended.

(4) The office shall provide each public safety answering point or regional emergency telecommunications center performing emergency medical dispatch in accordance with subdivision (1) of this subsection with initial training of emergency medical dispatch personnel and an

emergency medical dispatch priority reference card set.

Sec. 9. (NEW) (a) Not later than July 1, 2002, each municipality shall establish a local emergency medical services plan. Such plan shall include the written agreements or contracts developed between the municipality, its emergency medical services providers and the public safety answering point, as defined in section 28-25 of the general statutes, as amended by this act, that covers the municipality. The plan shall also include, but not be limited to, the following:

(1) The identification of levels of emergency medical services, including, but not limited to: (A) The public safety answering point responsible for receiving emergency calls and notifying and assigning the appropriate provider to a call for emergency medical services; (B) the emergency medical services provider that is notified for initial response; (C) basic ambulance service; (D) advanced life support level; and (E) mutual aid call arrangements;

(2) The name of the person or entity responsible for carrying out each level of emergency medical services that the plan identifies;

(3) The establishment of performance standards for each segment of the municipality's emergency medical services system; and

(4) Any subcontracts, written agreements or mutual aid call agreements that emergency medical services providers may have with other entities to provide services identified in the plan.

(b) In developing the plan required by subsection (a) of this section, each municipality: (1) May consult with and obtain the assistance of its regional emergency medical services council established pursuant to section 19a-183 of the general statutes, its regional emergency medical services coordinator appointed pursuant to section 19a-185 of the general statutes, its regional emergency medical services medical advisory committees and any sponsor hospital, as defined in regulations adopted pursuant to section 19a-179 of the general statutes, as amended by this act, located in the area identified in the plan; and

(2) shall submit the plan to its regional emergency medical services council for the council's review and comment.

Sec. 10. (NEW) (a) As used in this section, "responder" means any primary service area responder that (1) is notified for initial response, (2) is responsible for the provision of basic life support service, or (3) is responsible for the provision of service above basic life support that is intensive and complex prehospital care consistent with acceptable emergency medical practices under the control of physician and hospital protocols.

(b) Any municipality may petition the commissioner for the removal of a responder. A petition may be made (1) at any time if based on an allegation that an emergency exists and that the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder's performance, or (2) not more often than once every three years, if based on the unsatisfactory performance of the responder as determined based on the local emergency medical services plan established by the municipality pursuant to section 9 of this act and associated agreements or contracts. A hearing on a petition under this section shall be deemed to be a contested case and held in accordance with the provisions of chapter 54 of the general statutes.

(c) If, after a hearing authorized by this section, the commissioner determines that (1) an emergency exists and the safety, health and welfare of the citizens of the affected primary service area are jeopardized by the responder's performance, (2) the performance of the responder is unsatisfactory based on the local emergency medical services plan established by the municipality pursuant to section 9 of this act and associated agreements or contracts, or (3) it is in the best interests of patient care, the commissioner may revoke the primary service area responder's primary service area assignment and require the chief administrative official of the municipality in which the primary service area is located to submit a plan acceptable to the commissioner for the alternative provision of primary service area responder responsibilities, or may issue an order for the alternative

provision of emergency medical services, or both.

Sec. 11. (NEW) (a) Any municipality may petition the commissioner to hold a hearing if the municipality cannot reach a written agreement with its primary service area responder concerning performance standards. The commissioner shall conduct such hearing not later than ninety days from the date the commissioner receives the municipality's petition. A hearing on a petition under this section shall not be deemed to be a contested case for purposes of chapter 54 of the general statutes.

(b) In conducting a hearing authorized by this section, the commissioner shall determine if the performance standards adopted in the municipality's local emergency medical services plan are reasonable based on the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177 of the general statutes, as amended by this act, model local emergency medical services plans and the standards, contracts and written agreements in use by municipalities of similar population and characteristics.

(c) If, after a hearing authorized by this section, the commissioner determines that the performance standards adopted in the municipality's local emergency medical services plan are reasonable, the primary service area responder shall have thirty calendar days in which to agree to such performance standards. If the primary service area responder fails or refuses to agree to such performance standards, the commissioner may revoke the primary service area responder's primary service area assignment and require the chief administrative official of the municipality in which the primary service area is located to submit a plan acceptable to the commissioner for the alternative provision of primary service area responder responsibilities, or may issue an order for the alternative provision of emergency medical services, or both.

(d) If, after a hearing authorized by this section, the commissioner determines that the performance standards adopted in the

municipality's local emergency medical services plan are unreasonable, the commissioner shall provide performance standards considered reasonable based on the state-wide plan for the coordinated delivery of emergency medical services adopted pursuant to subdivision (1) of section 19a-177 of the general statutes, as amended by this act, model emergency medical services plans and the standards, contracts and written agreements in use by municipalities of similar population and characteristics. If the municipality refuses to agree to such performance standards, the primary service area responder shall meet the minimum performance standards provided in regulations adopted pursuant to section 19a-179 of the general statutes, as amended by this act.

Sec. 12. (NEW) (a) Not later than February 1, 2001, the Commissioner of Public Health shall submit to the joint standing committee of the General Assembly having cognizance of matters relating to public health a plan of action for the implementation of a pilot program, in not more than two municipalities that consent to participate in such pilot program, to assess the effect of assigning a primary service area to a selected provider of emergency medical services based on the issuance of requests for proposals with a right of first refusal granted to the provider that holds the primary service area at the time of such issuance. The plan of action shall identify the elements of and the means of implementing the pilot program, including, but not limited to: (1) The procedure for selection of the participating municipalities; (2) the design and measurement of standards for the pilot program; (3) the identification of emergency service factors to be assessed; (4) the identification of the evaluating entity; and (5) the estimated time period for the implementation and completion of the pilot program. The commissioner shall hold a public hearing on the plan of action prior to such submission. The joint standing committee of the General Assembly having cognizance of matters relating to public health shall meet to consider the plan of action not later than sixty days after the date of its submission. If the plan of action is rejected by the committee, the commissioner shall submit a revised plan of action not later than ninety days after the date

of such rejection.

(b) Unless otherwise modified or rejected by the joint standing committee of the General Assembly having cognizance of matters relating to public health, the pilot program shall begin on October 1, 2005. The pilot program shall, at a minimum, establish:

(1) An appropriate time frame within the expiration of a participating municipality's current emergency medical services contract for the initial issuance of requests for proposals and the initial selection of a provider of emergency medical services by the participating municipality under the pilot program, provided this subdivision shall not be construed to prevent a participating municipality from selecting or otherwise renewing any contract with its current provider of emergency medical services;

(2) An appropriate time period from the date of initial selection under subdivision (1) of this subsection after which a participating municipality may solicit requests for proposals from alternative providers of emergency medical services, provided such time period shall be reasonably sufficient to permit the initial provider to recoup any investment made for the purpose of providing emergency medical services in the participating municipality, but shall not exceed eight years;

(3) Criteria for selection and approval of an alternative provider of emergency medical services that submits a bona fide proposal, including, but not limited to, (A) a right of first refusal, granted to the provider that holds the primary service area at the time the requests for proposals are issued, that may be exercised by such provider if such provider makes a bona fide offer matching the proposal submitted by the selected alternative provider, (B) a requirement for approval by the legislative body of the participating municipality by a greater than majority vote, and (C) approval of any such selected alternative provider by the commissioner as appropriate to protect the public health and safety; and

(4) Requirements, including a timeframe, for reporting the status and results of the pilot program, and the recommendations of the commissioner with respect to the continuation or expansion of the pilot program, to the joint standing committee of the General Assembly having cognizance of matters relating to public health.

(c) Nothing in this section shall be construed to authorize the termination of any contract in effect on the date the pilot program begins or to otherwise interfere with any rights or duties created by any such contract.

Sec. 13. The Commissioner of Public Health shall study and make recommendations concerning the implementation of an expedited approval or reporting process or a waiver of any required approval for the operation of additional ambulances, invalid coaches, nontransport emergency vehicles and branch locations by persons or emergency medical service organizations licensed or certified under section 19a-180 of the general statutes, as amended by this act, where such operation is not a new service offered by any such person or emergency medical service organization and does not result in any change in rates. Not later than December 31, 2000, the commissioner shall submit a report of the commissioner's findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with section 11-4a of the general statutes.

Sec. 14. This act shall take effect July 1, 2000.

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:	Significant Cost (Enhanced 9-1-1 Telecommunications Fund), Minimal Cost
Affected Agencies:	Departments of Public Health, Public Safety
Municipal Impact:	Indeterminate Cost, Minimal Cost, Potential Savings, STATE MANDATE

Explanation

State and Municipal Impact:

This bill makes various changes to law concerning the emergency medical services and emergency medical dispatch systems. These changes and their associated fiscal impact are as follows:

Collection of EMS Data

The Department of Public Health (DPH) will incur an estimated cost of $249,845 in FY 01 to institute an emergency medical services (EMS) data collection system by October 1, 2001. Included in this sum is $44,800 in equipment funding for a computer, printer and server, $75,000 to purchase 250,000 trip record forms (at $0.30 each), $125,000 in data processing consultant costs and $5,045 in associated other expenses. The agency anticipates hiring staff required to oversee the data collection system within its current services budget before the end of FY 00. In FY 02 and subsequent fiscal years, a DPH cost of $200,000 - $250,000 will be incurred to reflect the ongoing operation of this program. DPH costs would be offset by up to $250,000 annually,

commencing in FY 01 from the Emergency 9-1-1 (E 9-1-1) Telecommunications Fund.

Municipally affiliated EMS companies will incur minimal costs to complete and forward tracking documents to the Department of Public Health on a quarterly basis, commencing October 1, 2001.

The bill expands the data collection program to rescue and management services by October 1, 2006. After that date, municipally affiliated EMS responders other than those licensed or certified as ambulance services will incur any resulting costs of completing and forwarding tracking documents to the Department of Public Health. The magnitude of any potential cost cannot be projected, as it would depend upon the data collection technology in use at that time.

It is anticipated that the DPH will be able to conduct audits to verify the accuracy of the reported information, conduct hearings involving EMS organizations failing to submit adequate information, compile a report summarizing the EMS data by March 31, 2002 and annually thereafter, and post this information upon its internet web site within its anticipated budgetary resources.

Beginning January 1, 2001, each public safety answering point (PSAP) would be required to submit quarterly reports to the Office of State-wide Emergency Telecommunications (OSET) in the Department of Public Safety on calls received for emergency medical services. OSET shall submit quarterly reports to the Department of Public Health. The costs to PSAPs would depend on the level of computerization and the number of EMS calls. It is anticipated that most would incur minimal additional costs. OSET estimates that it would require about one-half staff position to meet these data collection and reporting responsibilities, at an annual cost of about $30,000, financed by the E 9-1-1 Fund.

EMS Rate Setting Process

Streamlining the EMS rate setting process will result in a workload

reduction for the DPH and the Office of Health Care Access. Any resources that would otherwise have been dedicated to this function will be redeployed to other EMS-related regulatory duties.

EMS Outcome Measures

The DPH will be required to develop outcome measures for the EMS system and submit a report by July 1, 2002 and annually thereafter on progress toward the development of these outcome measures. This can be accommodated within the agency's anticipated budgetary resources.

Determination of Need

The bill requires the DPH to study and make recommendations regarding streamlining the determination of need process. The agency will be able to develop and submit the required report by December 31, 2000, within its anticipated budgetary resources.

Primary Service Area Assignment

The bill requires, by February 1, 2001, the DPH to report to the Program Review and Investigations Committee a plan for a pilot program to assess the effect of assigning primary service areas (PSAs) to EMS providers. It is anticipated that the DPH will be able to accomplish this duty within its anticipated budgetary resources.

Since the DPH currently assigns primary service area (PSA) responders for each PSA no fiscal impact will result from mandating this responsibility.

Holding hearings at the request of a municipality requesting a review of performance standards when disagreements exist between the town and its primary service area responder can be accommodated within the DPH's anticipated budgetary resources.

Municipalities electing to petition the DPH for the removal of a PSA responder may incur a minimal cost to the extent that town

representatives devote time to participate in the subsequent hearing process.

Local Emergency Medical Services Plans

The Office of Emergency Medical Services will be required to develop model local EMS plans and performance agreements. It is anticipated that this can be accommodated within the DPH's anticipated budgetary resources. Communities currently without local EMS plans may incur indeterminate legal costs associated with negotiating contracts with EMS providers and PSAPs. The bill requires each municipality to establish a local EMS plan by July 1, 2002.

Emergency Medical Dispatch System

By July 1, 2004, the bill requires that each PSAP must provide itself or arrange for emergency medical dispatch (EMD) to be provided by a public or private safety agency or a regional emergency dispatch center. Based on national standards, implementation of EMD requires dispatchers to attend an initial training program, the provision of medical protocol reference sets, and re-certification every two or three years. The bill requires OSET to provide or approve an EMD training course and EMD continuing education course and to provide each PSAP or center doing EMD with initial training and an EMD priority card reference set.

Information contained in the Program Review and Investigations Committee report, and verified by OSET, indicates that while EMD adds to the length of some medical emergency calls, it does not usually require an increase in the number of dispatchers. Most increases were very minor and could be handled with minor overtime costs. In addition, an analysis of the current volume of emergency calls handled by each PSAP in Connecticut indicates that most could handle an increase in the time per call with current staff. Therefore, minimal additional costs are anticipated from a minimal workload increase. The PSAPs and the municipalities that provide funding for them

would incur these potential minimal costs.

Since the EMD system does not have to be in place until FY 04, the costs for training existing personnel could be spread over three years. Total costs of about $195,000 would be incurred in FY 01. This estimate is based upon an assumption that 500 people would require training each year at a cost of about $300 each (for a total of $150,000). Additionally, OSET estimates that it would require one-half staff position to oversee EMD training responsibilities at an annual cost of about $30,000. In FY 01, a cost of approximately $15,000 would be incurred to purchase approximately 300 priority reference card sets, at a cost of $50 each. Ongoing costs of $180,000 would be experienced in FY 02 and 03, as personnel training and OSET oversight duties would recur. These costs would also be funded through the E 9-1-1 Fund.

Finally, the bill allows OSET to cover PSAP dispatcher re-certification costs, which range from $50 to $130 every two to three years. This, in addition to the training of new dispatchers would result in ongoing costs of about $150,000 per year.

E 9-1-1 Fund

The E 9-1-1 Fund is primarily financed through fees assessed against subscribers of local telephone service. It is a non-lapsing, non-appropriated fund. The resources of the fund must be used solely for expenses associated with the enhanced emergency 9-1-1 program. Estimated FY 00 collections are $9.14 million resulting from a $0.31 per telephone line surcharge. The surcharge is capped by statute at $0.50 per line. Each cent in the surcharge generates $250,000 to $300,000 per year.

C-MED Credit

The bill also requires that the credit for regional coordinated medical emergency direction (C-MED) services be increased to $0.15 per capita and maintained at that level. This results in costs to the E 9-1-1 Fund estimated at $150,000 in FY 01, $300,000 in FY 02, and

$450,000 annually beginning in FY 03. The C-MED credit was established in FY 97 at $0.25 per capita and has been reduced by $0.05 per year. It was established to provide partial relief to the local municipalities from the cost burden imposed by these operations, and then phased out in order to encourage the consolidation of dispatch centers. While this subsidy of C-MED services could potentially reduce costs to municipalities, the actual experience of municipalities in FY 97 indicated that few had any reduction in their costs for C-MED service. It should be noted that funding increases from the E 9-1-1 Fund has already offset the impact of the declining C-MED credit on the regional emergency communications centers.

House "A" modifies the original bill and fiscal note as follows:

Collection of EMS Data

It provides for ongoing subsidization of the costs of the emergency medical services (EMS) data collection system from the E 9-1-1 Fund. Up to $250,000 will be made available each fiscal year to pay for the collection, maintenance and reporting of EMS data. As the original bill restricted the subsidy to FY 01 only, the amendment precludes the need for future appropriation of General Fund moneys to the Department of Public Health (DPH).

It requires the expansion of the data collection program to rescue and management services by October 1, 2006. After that date, municipally affiliated EMS responders other than those licensed or certified as ambulance services will incur any resulting costs of completing and forwarding tracking documents to the Department of Public Health. The magnitude of any potential cost cannot be projected, as it would depend upon the data collection technology in use at that time.

It also clarifies the bill by stating that a public safety answering point (PSAP) may submit its quarterly report of EMS calls in an approved written or electronic form, and changes from annual to quarterly the frequency with which the Department of Public Safety

(DPS) must furnish the information to the DPH. This has no fiscal impact on DPS.

EMS Rate Setting Process

Streamlining the EMS rate setting process will result in a workload reduction for the DPH and the Office of Health Care Access. Any resources that would otherwise have been dedicated to this function will be redeployed to other EMS-related regulatory duties.

EMS Outcome Measures

The DPH will be required to develop outcome measures for the EMS system and submit a report by July 1, 2002, and annually thereafter on progress toward the development of these outcome measures. This can be accommodated within the agency's anticipated budgetary resources.

Primary Service Area Assignment

It is anticipated that the DPH will be able to develop and submit a plan regarding the implementation of a pilot program for the assignment of primary service areas (PSA) by February 1, 2001, within its anticipated budgetary resources.

Since the DPH currently assigns primary service area responders for each PSA, no fiscal impact will result from mandating this responsibility.

Holding hearings at the request of a municipality requesting a review of performance standards when disagreements exist between the town and its primary service area responder can be accommodated within the DPH's anticipated budgetary resources.

Municipalities electing to petition the DPH for the removal of a PSA responder may incur a minimal cost to the extent that town representatives devote time to participate in the subsequent hearing process.

Local Emergency Medical Services Plans

The amendment requires each municipality to establish a local emergency medical services plan by July 1, 2002. Communities currently without local EMS plans may incur indeterminate legal costs associated with negotiating contracts with EMS providers and PSAPs.

The Office of Emergency Medical Services will be required to develop model local EMS plans and performance agreements. It is anticipated that this can be accommodated within the DPH's anticipated budgetary resources.

C-MED Credit

The amendment limits the increase in the credit for regional coordinated medical emergency direction (C-MED) services from $0.30 to $0.15 per capita. The $0.15 is the per capita rate for the current fiscal year. This reduces the costs of the original bill by $450,000 per year beginning in FY 01.

Emergency Medical Dispatch System

The original bill required the E 9-1-1 Fund to pay for the reimbursement of emergency medical dispatch costs, to include start-up costs related to initial training of EMD personnel and the purchase of an EMD priority reference set, and costs of ongoing training of EMD personnel. The amendment expands activities to be funded from the E 9-1-1 Fund to include continuing education provided by the Office of Statewide Emergency Telecommunications (OSET). This does not result in additional costs, because the fiscal note on the original bill assumed that the E 9-1-1 Fund would finance these ongoing training and continuing education costs.

The amendment also requires the OSET to provide each PSAP or regional emergency telecommunications center performing EMD with initial training and EMD priority reference card sets. The original bill called for the OSET to instead reimburse each PSAP for the training

and card sets. This could result in reduced costs through the negotiation of a master contract for statewide training and reference card sets. The amount of savings cannot be determined at this time.

Determination of Need

The amendment requires the DPH to study and make recommendations regarding streamlining the determination of need process. The agency will be able to develop and submit the required report by December 31, 2000, within its anticipated budgetary resources.

Other Changes

Other changes in the amendment are technical in nature or remove obsolete statutory references and have no associated fiscal impact.

OLR Amended Bill Analysis
sHB 5287 (as amended by House "A")*

AN ACT CONCERNING EMERGENCY MEDICAL SERVICES DATA COLLECTION AND EMERGENCY MEDICAL DISPATCH.

SUMMARY:
This bill makes a number of changes in the state's emergency medical services (EMS) system including:

1. requiring the Department of Public Health (DPH) to collect specific EMS data from licensed and certified ambulance services and other EMS-related entities on a quarterly basis and prepare an annual report based on this data;

2. allowing DPH to impose penalties on those not submitting the required data;

3. requiring each public safety answering point (PSAP) to submit information quarterly to the Office of State-Wide Emergency Telecommunications on EMS calls received and requiring the office to provide DPH with this information annually;

4. requiring each PSAP, by July 1, 2004, to provide emergency medical dispatch (EMD) or arrange for it to be provided by a public or private safety agency or regional telecommunications center, for 9-1-1 calls the PSAP receives that require emergency medical services;

5. requiring the office to provide or approve an EMD training course and to assist PSAPs or centers with EMD training;

6. providing funding, through the enhanced emergency 9-1-1 program funding mechanism, for the DPH data collection activities and certain EMD costs;

7. requiring DPH to develop outcome measures for the EMS system;

8. requiring each municipality to establish a local EMS plan and requiring the Office of Emergency Medical Services to develop model local EMS plans;
9. allowing any municipality to petition the DPH commissioner to remove a primary service responder not meeting certain performance standards;

10. requiring DPH to develop a plan for a pilot program for assigning primary service;

11. requiring DPH to adopt regulations addressing procedures and conditions for filing rate increase requests; and

12. requiring DPH to study an expedited approval or waiver process for additional EMS vehicles and locations.

The bill also makes technical changes.

*House Amendment "A" replaces the original bill.

EFFECTIVE DATE: July 1, 2000

DATA COLLECTION SYSTEM

By law, the DPH commissioner must develop a data collection system that follows a patient from initial entry into the system through discharge from the emergency room. The bill, instead, directs DPH to develop the EMS data collection system by October 1, 2001 and follow the patient from initial EMS entry through emergency room arrival. The bill requires DPH to collect the following on a quarterly basis from each licensed or certified ambulance service providing EMS:

1. the total number of calls for EMS service received during the reporting period;

2. the level of EMS required for each call;

3. the response time for each ambulance service given during that period;

4. the number of passed, cancelled, and mutual aid calls during that

period ("a mutual aid call" is a call for EMS that, according to a written agreement, a secondary or alternate EMS provider responds to because the primary or designated provider cannot because it is responding to another call or the vehicle is out of service); and

5. the prehospital data for the unscheduled transport of patients for that period.

This information can be submitted in any DPH-approved written or electronic form the service chooses. DPH must consider the services' needs in approving the form. DPH can audit the service as necessary to verify the reported information's accuracy.

Beginning October 1, 2006, DPH must also collect this information from each licensed or certified EMS person or organization. The information must be included in DPH's annual report (see next section) beginning October 1, 2006.

DPH Report

The bill directs DPH to prepare a report for the year that includes:

1. the total number of calls for EMS received during the reporting year by each licensed or certified ambulance service;

2. the level of EMS required for each call;

3. the name of the provider of each level of EMS given during the reporting year;

4. the response time (in time ranges or fractile response times) for each provider using a common definition of response time; and

5. the number of passed, cancelled, and mutual aid calls.

This report must be in a format that categorizes the information for each town in which the EMS was provided, grouped according to urban, suburban, and rural categories. Annually, beginning by March 31, 2002, DPH must submit this report to the Public Health Committee, make it publicly available, and post it on the Internet.

Penalties

Under the bill, the commissioner can impose certain penalties on a licensed or certified ambulance service that fails to submit the required information. DPH must issue a written order directing the service to comply with the reporting requirement if (1) the service does not submit information for six consecutive months or (2) if DPH believes the service knowingly or intentionally submitted incomplete or false information.

If the service does not fully comply with the order within three months from its issuance, DPH (1) must hold a hearing at which the service must show cause why its primary service area assignment should not be revoked and (2) can take a variety of disciplinary actions against the service (e.g. license revocation or suspension, censure, letter of reprimand, probation, civil penalties) as it deems appropriate.

Licensed or certified persons or EMS organizations required to provide the information are also subject to these penalties beginning October 1, 2006.

PSAP REPORTING

Beginning January 1, 2001, the bill requires each PSAP to submit quarterly reports to the Office of State-wide Emergency Telecommunications of the calls it received for EMS. A "PSAP" is a facility operated 24 hours a day to receive 9-1-1 calls and, as appropriate, directly dispatch emergency response services or transfer or relay emergency 9-1-1 calls to other public safety agencies.

The report must include (1) the number of 9-1-1 calls during the quarter involving a medical emergency and (2) for each call, the elapsed time between when the call was received and answered and between when the call was answered and emergency response services were dispatched or the call was transferred or relayed to another public or private safety agency (this must be reported in time ranges or fractile response times). The information can be submitted in any written or electronic form chosen by the PSAP and approved by public safety commissioner. He must consider the PSAP's needs in approving the method. Quarterly, the office must give this information to DPH and make it available to the public, including via Internet posting.

EMERGENCY MEDICAL DISPATCH

Under the bill, by July 1, 2004, each PSAP must itself provide or arrange for emergency medical dispatch (EMD) to be provided by a public or private safety agency or a regional emergency telecommunications center, for all 9-1-1 calls received by the PSAP that require EMS. "Emergency Medical Dispatch" means the management of requests for emergency medical assistance using a system of (1) tiered response or priority dispatching of emergency medical resources based on the level of assistance needed and (2) prearrival first aid or other medical instructions given by trained personnel who are responsible for receiving 9-1-1 calls and directly dispatching emergency response services. Any PSAP arranging for EMD from a public or private agency or regional center must file with the office documentation demonstrating that the agency or center satisfies the bill's requirements.

An EMD program must include:

1. medical interrogation, dispatch prioritization, and prearrival instructions for 9-1-1 calls requiring EMS that are provided only by personnel who have satisfactorily completed an EMD training course offered or approved by the office;

2. a medically approved EMD priority reference system;

3. EMD continuing education;

4. a mechanism to detect and correct discrepancies between established EMD protocols and actual practice; and

5. a quality assurance component prepared with the assistance of an emergency medicine physician, to monitor EMD time intervals, use of EMD program components, and appropriateness of EMD instructions and protocols. (There must be an ongoing review of the EMD program's effectiveness.)

EMD Training

By July 1, 2001, the bill requires the office either to provide or approve an EMD training course and a continuing education course that meets requirements of the U.S. Department of Transportation, National

Highway Traffic Safety Administration, EMD: National Standard Curriculum.

The bill requires the office to provide each PSAP or regional center doing EMD with initial training of EMD personnel and an EMD priority reference card set.

FUNDING FOR ENHANCED EMERGENCY 9-1-1

Existing law requires the public safety commissioner to determine and specify the funding needed for development and administration of the enhanced Emergency 9-1-1 (E 9-1-1) program. This includes (1) purchasing and maintaining new PSAP terminal equipment, (2) subsidizing regional public safety emergency centers, (3) establishing a transition grant program to encourage regionalization of public safety communication, (4) establishing a regional emergency telecommunications service credit to support regional dispatch services, (5) necessary personnel training, (6) recurring expenses and future capital costs of the telecommunications network used to provide E 9-1-1 services, and (7) administrative expenses of the office.

To pay for the expenses of the E 9-1-1 program, the Department of Public Utility Control (DPUC) establishes a monthly assessment on each local telephone and commercial mobile radio service subscriber as defined by federal law.

This bill adds, for FY 2000-01 and afterwards, the expenses of developing the EMS data collection system and reporting by DPH to the items that determine the amount of funding the E 9-1-1 system needs. The bill specifies that the expenses for the data collection and reporting activities cannot exceed $250,000 in any fiscal year. It specifies that, for FY 2000-01 and afterwards, the regional emergency telecommunication service credit for coordinated EMS must be based on a factor of 15 cents per capita and cannot be reduced each year.

The bill also adds, beginning in FY 2000-01, and afterwards, the reimbursement for initial training of EMD personnel, providing an EMD reference card set, and EMD training and continuing education.

EMS RATE INCREASES

By law, DPH must establish EMS rates and regulations that establish

rate-setting methods. The bill requires the regulations to specify that, beginning July 1, 2000, (1) rate increase requests can be filed only once a year; (2) only licensed and certified ambulance services that file for a rate increase and do not accept the maximum allowable rates contained in any voluntary statewide rate schedule established by the commissioner for the rate application year must file detailed financial information; (3) licensed and certified ambulance services that do not apply for an increase in a given year or that accept the maximum allowable rates in the voluntary rate schedule must file, by July 15, (a) an audited financial statement or an accountant's review report for the most recently completed fiscal year including total revenue and total expenses, (b) a statement of call volume, and (c) if the service is not applying for an increase, a written declaration that no change in the current maximum rates has occurred; and (4) detailed financial and operational information filed by licensed and certified ambulance services seeking a rate increase must cover the time period from their last request.

OUTCOME MEASURES

The bill requires the DPH commissioner to research, develop, and implement appropriate, quantifiable outcome measures for the state's EMS system. By July 1, 2002 and annually afterwards, he must report to the Public Health Committee on his progress and, after the measures are implemented, on the outcomes.

LOCAL EMERGENCY SERVICES PLANS

The bill requires each municipality to establish a local EMS plan by July 1, 2002. It must include written agreements or contracts between the town, its EMS providers, and the PSAP covering the municipality. The plan must also include (1) identification of levels of EMS, including (a) the responsible PSAP, (b) the EMS provider notified initially, (c) basic ambulance service, (d) advance life support level, and (e) mutual aid call agreements; (2) the person or entity responsible for each EMS level identified in the plan; (3) performance standards for each part of the town's EMS system; and (4) any subcontracts, written agreements, or mutual aid call agreements that EMS providers have with other entities.

In developing the plans, municipalities can get help from their regional EMS council and coordinator, regional EMS medical advisory

committees, and any sponsor hospital located in the plan area. The plan must be given to the regional EMS council for review and comment.

Model Local EMS Plans

By July 1, 2001, the bill requires the Office of Emergency Medical Services (OEMS), with the advice of the EMS Advisory Board and the regional EMS councils, to develop model local EMS plans and performance agreements to aid municipalities in developing such plans. OEMS must consider (1) the difference in delivering EMS in urban, suburban and rural settings; (2) the statewide plan for coordinated delivery of EMS; and (3) guidelines, standards, and contracts or written agreements used by towns with similar populations and characteristics.

PRIMARY SERVICE AREA RESPONDERS

The bill allows any town to ask the DPH commissioner to remove a responder. A "responder" is any primary service area responder (1) notified for initial response, (2) responsible for basic life support, or (3) responsible for intensive and complex prehospital care above basic life support that is consistent with acceptable emergency medical practices under the control of physician and hospital protocols. A "primary service area responder" is the EMS provider designated to respond in a primary service area. A "primary service area" is a specific municipality or part of one to which one designated EMS provider is assigned for each category of emergency medical response services.

The bill requires the DPH commissioner to establish primary service areas and assign in writing a primary service area responder for each primary service area. He can revoke primary service area assignment in the best interests of patient care.

Responder Removal

A municipality can petition the commissioner for a responder's removal (1) at any time based on an allegation that an emergency exists and the safety, health, and welfare of the primary service area's citizens are jeopardized by the responder's performance or (2) not more than every three years on the basis of unsatisfactory responder performance under the local EMS plan established by the town and

associated agreements or contracts. A hearing on a petition is a contested case under the Uniform Administrative Procedures Act (UAPA).

After a hearing, the commissioner can (1) revoke the responder's primary service area assignment and require the affected town's chief administrative official to submit a plan acceptable to the commissioner for alternative primary service responder responsibilities, (2) issue an order for alternative EMS provision, or (3) do both. To take any of these actions, he must find that (1) an emergency exists and the responder's performance jeopardizes the health and safety of those in the affected area, (2) the responder's performance is unsatisfactory based on the local EMS plan, or (3) it is in the best interests of patient care.

Performance Standards

A municipality can ask the commissioner to hold a hearing if it cannot reach a written agreement with its responder on performance standards. The hearing must be held within 90 days after receiving the petition. This hearing is not a contested case under the UAPA.

In the hearing, the commissioner must determine if the performance standards in the town's local EMS plan are reasonable, based on the statewide plan for the coordinated delivery of EMS, model local EMS plans, and the standards and agreements used by similar municipalities.

If the commissioner determines, after the hearing, that the performance standards in the local EMS plan are reasonable, the responder has 30 days to agree to them. If the responder fails or refuses to agree to the standards, the commissioner can (1) revoke the responder's primary service area assignment and require the town's chief administrative official to submit an acceptable plan for alternative primary area responder responsibilities, (2) issue an order for alternative EMS provision, or (3) do both.

If the commissioner determines, after the hearing, that the adopted standards are unreasonable, he must provide reasonable performance standards based on the statewide plan for coordinated EMS delivery, model EMS plans, and the standards and agreements used by similar towns. If the town refuses to agree to such performance standards, the

responder must meet minimum performance standards in state regulations.

Currently, DPH must adopt regulations on licensure and certification of the operations, facilities, and equipment of EMS organizations. Under the bill, these regulations must require that, as an express condition of purchasing any business that holds a primary service area, the purchaser must agree to abide by any performance standards to which the business was obligated according to an agreement with the municipality.

PRIMARY SERVICE AREA ASSIGNMENT PILOT PROGRAM

By February 1, 2001, the DPH commissioner must provide the Public Health Committee with a plan for implementing a pilot program in one or two towns that examines the effect of assigning primary service areas to select EMS providers based on periodic requests for proposals (RFP) with a right of first refusal to the provider holding the primary service area when the RFP is issued.

DPH's plan must address (1) procedures for selecting the towns for the pilot; (2) design and measurement of standards; (3) assessment factors; (4) identifying an evaluation entity; and (5) the period for program completion and reporting. The commissioner must hold a public hearing before he submits the plan.

The Public Health Committee must meet to consider the plan within 60 days of its submittal. If it rejects the plan, the commissioner must submit a revised plan within 90 days. The pilot program must begin on October 1, 2005 unless otherwise modified or rejected by the committee.

The pilot program must at least establish:

1. an appropriate time frame within the expiration of a municipality's current EMS contract for the initial issuance of RFPs and initial selection of an EMS provider by the municipality under the pilot program (but not to be construed to prevent a participating municipality from selecting or renewing any contract with its current EMS provider);

2. an appropriate time period from the date of initial selection after

which the municipality can solicit RFPs from alternative EMS providers (sufficient to allow the initial provider to recoup any investment made to provide EMS in the town but not more than eight years);

3. criteria for selecting and approving an alternative EMS provider that submits a bona fide proposal including (a) a right of first refusal for the provider in place when the RFP was issued, (b) a requirement for approval by the municipality's legislative body by a greater than majority vote, and (c) approval of the alternative provider by the commissioner as appropriate to protect the public health and safety; and

4. requirements for reporting the pilot program's status and results to the Public Health Committee as well as the commissioner's recommendations for continuing or expanding the program.

The bill specifies that it should not be construed to authorize termination of any contract in effect at the time the pilot program begins or otherwise interfere with any contractual rights or duties.

ADDITIONAL EMS VEHICLES AND LOCATIONS

The bill requires DPH to study and make recommendations on implementing an expedited approval or reporting process or a waiver of any required approval to operate additional ambulances, invalid coaches, nontransport emergency vehicles, and branch locations by licensed or certified people or EMS organizations. Such operations must not be a new service offered by the person or organization and cannot result in a rate change.

DPH must report on the study to the Public Health Committee by December 31, 2000.

BACKGROUND

Legislative History

The House referred the bill to the Appropriations Committee on March 31. The committee reported it favorably without change on April 4. The House referred the bill to the Public Safety Committee on April 7. The committee reported it favorably on April 12 without change. The

House then referred the bill to the Planning and Development Committee on April 13. The committee reported it favorably without change on April 17. On April 18, the House referred the bill to the Legislative Management Committee, which reported it favorably without change on April 24.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 22 Nay 0

Appropriations Committee

Joint Favorable Report
Yea 44 Nay 0

Public Safety Committee

Joint Favorable Report
Yea 22 Nay 0

Planning and Development Committee

Joint Favorable Report
Yea 13 Nay 4

Joint Committee on Legislative Management

Joint Favorable Report
Yea 22 Nay 5